Massachusetts Department of Public Health
Request for Restrictions on Use and Disclosures of Confidential Information

Name:_____

Address:_____

Phone # _____ Date of Birth: ___/ ___/ ___

REQUESTED RESTRICTION: Please describe the type of restriction you desire, and the programs to which your request applies. **Please note**: 1) Only the programs listed will be required to comply with this request. 2) DPH cannot agree to restrict disclosures required by law. 3) Even if your request is approved, disclosures to you will not be restricted.

_____

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My request applies to (Check one and indicate date(s)):

[ ] Communications about this date only ___/ ___/ ___; or

[ ] From this date ___/ ___/ ___ until I indicate otherwise; or

[ ] From this date ___/ ___/ ___ to this date ___/ ___/ ___.

_____ ___/ ___/ ___

Your Signature or Signature of Personal Representative Date

_____
Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information:
___ Person signing is the individual
___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority._____

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DPH Use Only

DPH Decision

[ ] Request Approved **[ ] Request Denied**

_____

_____

_____

_____

_____

By:

_____

Signature Title Date

DPH is required to inform you of your right to file a complaint about this decision.

With DPH:
Privacy Office
Massachusetts Department of
Public Health
250 Washington St.
Boston, MA 02108
Phone: 617-624-6083

With the Department of Health & Human Services:
Regional Manager, Office for Civil Rights
DHHS Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, Massachusetts 02203
Phone: 617-565-1340
FAX: 617-565-3809 TDD: 617-565-1343

Your complaint must be in writing, filed within one hundred eighty (180) days of when you knew or should have known of the denial, and name DPH as the party you are complaining against.